Moving Toward Health Care Transformation

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The National Rural Health Resource Center (The Center) is a nonprofit organization dedicated to sustaining and improving health care in rural communities. As the nation’s leading technical assistance and knowledge center in rural health, The Center focuses on five core areas:

• Transition to Value and Population Health
• Collaboration and Partnership
• Performance Improvement
• Health Information Technology
• Workforce
• High cost
• Low quality
• High chronic illness
• Low access
Triple Aim
• Better health
• Better care
• Lower cost

• Better Care
• Smarter Spending
• Healthier People
Alternative Payment Models and Sustainability, Advance Interoperable HIE Program Senior Leader Call, February 24, 2016, John Rancourt, Deputy Director, Office of Care Transformation,
HHS/CMS will achieve Goal 1 through alternative payment models where providers are accountable for both cost and quality.

**Major APM Categories**

**Accountable Care Organizations**
- Medicare Shared Savings Program ACO*
  - Pioneer ACO*
  - Comprehensive ESRD Care Model
  - Next Generation ACO

**Bundled Payments**
- Bundled Payment for Care Improvement*
  - Comprehensive Care for Joint Replacement
  - Oncology Care

**Advanced Primary Care**
- Comprehensive Primary Care*
- Multi-payer Advanced Primary Care Practice*

**Other Models**
- Maryland All-Payer Hospital Payments*
- ESRD Prospective Payment System*

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CMS will continue to test new models and will identify opportunities to expand existing models.

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* MSSP started in 2012, Pioneer started in 2012, BPCI started in 2013, CPC started in 2013, MAPCP started in 2013, Maryland All-Payer started in 2014 ESRD PPS started in 2011
Accountable Care Organizations:

• A mechanism to monetize value by increasing quality and reducing cost

• A group of health care providers that takes responsibility for the cost and quality of care for a group of patients or individuals
Rural Health Value, “Understanding the Social Determinants of Health: A Self-Guided Learning Module for Rural Health Care Teams.”, RUPRI, Stratus Health
• Networks make these payment models work
  ◦ Create infrastructure
  ◦ Build trust and collaboration
  ◦ Share and analyze information
  ◦ Creating collective volume
  ◦ Creating economies of scale
A health system that links health care with community stakeholders to create a network of organizations working together to improve population health
Speakers

- Tim Rine and Trisha Cook
- Tara Dilley
- Gina Brien
North Coast Quality Improvement Network

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North Coast Clinics Network

• **Service Area:** Northwest California
  ◦ Humboldt, Del Norte, and Trinity Counties

• **Geography:** small communities designated rural & frontier

• **Poor Health:** 43rd, 44th, and 54th out of 57 counties in California for overall rankings in health outcomes.

• **Members:**
  ◦ Open Door Community Health Centers (13 sites, 2+ satellites)
  ◦ Redwoods Rural Health Center (1 site, 2 satellites)
  ◦ Southern Trinity Health Services (1 site, 2 satellites)

• **Patient Population:** 60,000 patients – 1 in 3 individuals
• **Overall goal:** to improve population health by implementing promising practices, and evidence-based approaches to address health disparities in our communities through the use of technology and collaboration.

• **Programmatic Areas:**
  1. Population Health Data Analytics
  2. Model of Improvement Capacity
  3. Culture of Continuous Quality Improvement
  4. Peer Networking & Expertise Exchange
  5. Evaluation & Sustainability
Health Care Transformation

• **Culture Change**
  ◦ Care Teams
  ◦ QI Department & QI Teams
  ◦ Patient Advisory Group

• **Training & Education**
  ◦ ABC’s of QI
  ◦ Treating Patients with C.A.R.E.
  ◦ Trauma Informed Care
  ◦ Motivational Interviewing
  ◦ Staying Healthy Classes
  ◦ Our Pathways to Health

• **QI Support**
  ◦ Practice Coaching
  ◦ Data Dashboards
Keepin’ It Rural Collaborative
- 3 HCCNs, 17 FQHCs with 46 sites
- 13 Counties, 40,000 square miles

• Rural Roundtables & Peer Networks
  - CEOs, COOs, CFOs, QI, Outreach & Enrollment

• Data Analytics
  - Regional Education for stakeholders
    - UDS Aggregation
    - Data sets and white papers
    - RUDI Data
    - Alternative Access
    - Social Determinants of Health

• Partnership Building & Collaboration
  - Community-based organizations (DHHS, IPA, Food Bank, Resource Centers)
  - Partnership HealthPlan of California (Medicaid Managed Care Plan)
  - Regional Associations of California (14 HCCNs)
Lessons Learned

- **Network as convener and facilitator**

- **Diversity of skills, locations, and patients**

- **Competing Demands for Data**

- **Healthcare Access and QI capacity**

- **Sharing of Best Practices**
Innovative Ways of Achieving the Triple Aim:

Tara Dilley
Texas Rural Accountable Care Organization (TRACO)
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Network Overview

- **Southeast Texas Health System (SETHS)**
  - Established in 1994
  - 9 independent member owners
    - CAH, Rural PPS, Community Health Centers, FQHCs, RHCs and independent physician clinics
- **Geographic location:** Texas gulf coast region
- **Mission:** To integrate health care locally and regionally for purposes of responding to the growth of managed care in a way that preserves local control and maintains the independence of the member institutions.
- **Project background:**
  - TRACO was formed in response to the changing landscape of healthcare:
    - Rural providers are faced with the challenge to transform their delivery system from cost based reimbursement and fee for service (pay for volume) to care management and population health with improved quality (pay for value). Navigating through the ACO requirements from a rural perspective is the intent of this grant.
• Strong/Respected leadership within each community
• Each community employs an RN Care Coordinator
  ◦ Priority is to cross reference internal data with CMS data to identify the top 10-15% of high cost utilizers attributed to each site; attribution list is updated quarterly
  ◦ Engage providers to address the identified patients; meet with the patients and create individualized care plans
• Engaging providers and practice managers
• Utilizing CMS data (Part A, B and D) and quality scores to identify high cost providers/facilities
• Shifting how providers work together
  ◦ Care Coordination, quality metrics/reporting and shared patient care
Preparing Members for Success

• Utilizing Medicare claims data to get a “whole picture of health” for each patient
  ◦ Part A, Part B and Part D claims
• Acting upon the claims data to define/redefine healthcare partners (tertiary, consults, post-acute, etc.)
• Engaging Care Coordinators with providers and patients
  ◦ Caseload priority is the top 10-15% of high cost utilizers from attribution lists
    • These patients comprise the majority of Medicare spending
  ◦ CCs cross reference internal patient data to CMS attributed patient data (changes quarterly)
• Utilize existing and new reimbursable services: CCM (chronic care management), TCM (transitional care management) and Advanced Care Planning (ACP)
• Ensuring all visits are coded, as appropriate; this will potentially increase the facility’s risk adjustment (which can increase payments)
• Increasing Annual Wellness Visits
  ◦ Capture 11 quality measures and Increases attribution
Lessons Learned

• Establish Peer communities
• Care Coordination is very gray...requiring a certain type nurse
• Patient engagement: face-to-face versus “cold calling”
• Code everything that’s appropriate for the visit
• Make sure data that is entered is easy to retrieve
• Be patient
• He, who holds the data, wins the game!
Appalachian Kentucky Health Care Access Network

Gina Brien
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• Expanded from a consortium covering 3 counties to a Network covering 32 counties
• Vision: Increase and improve healthcare access for all low-income, uninsured, underinsured residents, both documented and undocumented, of rural Kentucky.
• Mission: Increase the number of Community Health Workers (CHWs) in the Commonwealth of Kentucky by expanding our Network to include partners throughout Western Appalachian Kentucky and developing training programs for CHWs.
Network Members

- Independent and District Local Health Departments
- Kentucky Department for Public Health – Office of Healthy Equity; Chronic Disease Branch
- Two Regional Hospitals
- Local FQHC
- University of Kentucky Area Health Education Center (AHEC)
- University of Kentucky Center of Excellence in Rural Health
- Kentucky Health Information Exchange
- Kentucky Population Health Institute
- Northeast Kentucky AHEC
- Northeast Kentucky Regional Health Information Organization
- Local Community College
- Local Providers

Innovations
NATIONAL RURAL HEALTH RESOURCE CENTER
Tiered Training Approach

**Tier 1**
- Basic curriculum approved by the Network
- One Week
- Classroom-Based
- Already in existence
- Developed by a Network Partner

**Tier 2**
- Specialty training
- Evidence-based programs
- Network members trained as Master Trainers
- Evidence-based curriculum includes:
  - Stanford Chronic Disease Self-Management
  - Stanford Diabetes Self-Management Education
  - Mental Health First Aid
  - Diabetes Prevention Program
  - National Center for Healthy Housing’s
  - Healthy Homes for CHWs

*Rural Health Innovations*
*NATIONAL RURAL HEALTH RESOURCE CENTER*
CHWs and the Triple Aim

- **Better Health** – CHWs trained in evidence-based programs that provide self-management skills and techniques
- **Better Care** – CHWs serve as advocates for the individual on behalf of their needs
- **Better Cost** – CHWs educate clients on proper health care utilization
Health Care Transformation

Networks
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